DIVISION OF MATERNAL AND CHILD HEALTH

Authorization for Services

1. **Vendor Name**: _____

2. **Vendor Address**: _____ **Vendor Tax ID #**:_____

   _____ **Phone Number:**_____

3. **Name of Patient**: _____ 4. **Birth Date**: _____

5. **Patient's Address**: _____ 6. **County of Residence**: _____

   _____ 7. **Clinic Location**: _____

8. Name of Parents or Guardian, if applicable: _____

9. Diagnosis: _____

10. Type of Service (check one): Physician Services ☐ Other (specify) ☐ _____
    Metabolic formula ☐ Metabolic food products ☐

11. Specify Services Requested: Itemized Charges:

    _____ _____

    _____ _____

    _____ _____

12. **TOTAL** $_____

13. _____ 14._____
    P.O.E./Agency Personnel Requesting Service(s) — Date of Service(s)

15. _____ 16._____
    Patient or Responsible Party Receiving Service(s) (Signature) — Date Received

17. _____ 18._____
    Vendor (Signature) / Providing Service(s) — Date of Service(s)

STATE AGENCY USE ONLY
Expenditures Authorized

Amount $_____ Date: _____

Authorized By: _____

Please submit **ORIGINAL** to:

Cabinet for Health Services
Division of Maternal and Child Health
275 East Main Street, HS2W-C
Frankfort, Kentucky 40621-0001

Attention:

KY Metabolic Foods & Formula Program
Phone: 502-564-3756 x4367
Fax: (502) 564-1510